Kentucky Department for Medicaid Services

Pharmacy and Therapeutics Advisory Committee Recommendations

February 6, 2003, Meeting (Makeup Meeting for January)

This chart provides a summary of the recommendations that were made by the Pharmacy and Therapeutics Advisory Committee at the February 6, 2003, meeting. Review of the recommendations by the Secretary of the Cabinet for Health Services and final decisions are pending.

	Description of Recommendation	P & T Vote
#1	• Place Zyrtec liquid 5mg/5ml with a quantity limit of 150ml/ month, and loratadine OTC (e.g. Alavert, Claritin, generic loratadine - tablets and liquid formulations) on the Preferred Drug List. • Place a prior authorization requirement on Allegra (all strengths and combination products), Clarinex (all strengths and dosage forms including any future decongestant combination products), Zyrtec tablets (all strengths), and Zyrtec liquid 10mg/10ml.	Passed 11 to 0
#2	• Approval of a non-preferred non-sedating antihistamine (listed above) will be based on evidence of a therapeutic failure of a 30-day trial of loratadine within the previous 12 months. This will be implemented using an electronic claims step edit.	Passed 11 to 0
#3	• Approval of a combination product (e.g. Zyrtec-D, Allegra-D) will be based on evidence of a therapeutic failure of at least a 30 day trial within the past 120 days with Claritin (loratadine), Zyrtec (cetirizine), Allegra (fexofenadine) or Clarinex (desloratadine), or a 30 day trial of an intranasal corticosteroid within the same 120 day period.	Passed 11 to 0
#4	For Celebrex, Vioxx, and Bextra; the following prior authorization criteria apply: • Prior authorization is not required for recipients 60 years of age and older. • For recipients under the age of 60, prior authorization will be granted if: o The recipient has a history of a documented gastric or duodenal ulcer, or positive H. Pilori infection; o The recipient has a history of an endoscopically documented nonsteroidal anti-inflammatory drug (NSAID) induced gastritis with hemorrhage, or o The recipient must concurrently receive a corticosteroid, warfarin, or DMARD drug; or o The recipient has had two failed trials of other NSAIDs (at an approved prescription dosage) that were due to a lack of tolerability; or o The recipient has a significant comorbidity that would predispose to adverse outcomes in the setting of a gastrointestinal hemorrhage, perforation or obstruction. • Prior authorization for celecoxib (but not rofecoxib) will be granted for recipients with a diagnosis of familial adenomatous polyposis. • PA may be authorized for up to 12 months in these situations.	Passed 11 to 0
#5	• Vioxx (rofecoxib) 50mg may be approved for a 5 day maximum only	Passed 11 to 0